State of Kansas
KanCare Health Homes
Concept Paper

Background

Upon assuming office, Governor Sam Brownback tasked his Lieutenant Governor, Dr. Jeff Colyer, to lead Medicaid reform efforts. Dr. Colyer formed a Health and Human Services Sub-cabinet, made up of the Secretaries of the state agencies concerned with overseeing or managing Medicaid programs. Through an extensive process of stakeholder engagement and public forums, the State determined to implement a comprehensive, integrated managed care program for all Medicaid services, including physical and behavioral health care, long term services and supports and some institutional care.

This program is known as KanCare and is scheduled to launch January 1, 2013, with three managed care organizations (MCOs) providing services statewide to more than 380,000 Kansas Medicaid and Children's Health Insurance Program (CHIP) members. Populations not included in KanCare are:

- State-funded limited service programs, e.g. MediKan, AIDS Drug Assistance Program, Special Tuberculosis Program (All of which total about 4,300 people in State fiscal year 2012)
- SOBRA (1,910 people in SFY 2012)
- Individuals who reside in public ICFs/MR (351 people in SFY 2012)
- Individuals who elect PACE (364 people in SFY 2012)

Local education agency and early childhood intervention services provided to Medicaid-eligible children as part of their Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) are not included in KanCare, although other Medicaid services these children receive will be part of KanCare. Additionally, the KanCare health plans are required to coordinate with the schools and providers of these IEP and IFSP services.

In order to effectively implement KanCare, the State submitted an 1115 demonstration request to waive certain federal requirements and allow mandatory enrollment of all populations, except for Native Americans, and to shorten the choice period during MCO enrollment from 90 to 45 days. Further information about KanCare and the 1115 waiver can be found at this website: http://www.kancare.ks.gov/ .

A key component of KanCare is the provision of health homes statewide to both children and adults beginning at the end of the first year of implementation to persons with mental illness or diabetes or both. Kansas envisions these health homes to be provided through a combination of MCO services and direct provider services. The health home model will be unique to Kansas and build on a foundation of strong community service provision.

Preparation

In the spring of 2012, the Kansas Department of Health and Environment (KDHE), the single state Medicaid agency, formed an interagency project team with membership from KDHE and the Kansas Department on Aging and Disability Services (KDADS). A project timeline was developed. At about the same time, a stakeholder advisory group was formed to help begin the

process of educating stakeholders and collecting input on the project. This stakeholder group is made up of representatives from FQHCs, Community Mental Health Centers, substance use disorder providers, Community Developmental Organizations, Centers for Independent Living, physicians and hospitals. Early work with this group involved educating members about health homes, discussing some co-location pilots operated by clinics and hospitals with behavioral health providers, and reviewing draft quality goals. The next scheduled discussion will center around beginning to define health home services.

Once the three MCO contracts were signed, external stakeholder workgroups were formed, one of which was tasked with providing additional input into the health homes project. This workgroup, the Specialized Health Care and Network Issues (SHNI) workgroup, has already provided some initial feedback to the State concerning our draft quality goals.

In late July and early August, State staff went to eight cities and held a meeting with providers and a meeting with members to help educate them about KanCare. As part of that process, the topic of health homes was covered. Additional educational tours are planned specifically for home and community-based services providers and recipients, as well as for the entire Medicaid and CHIP population.

In early August 2012 Kansas submitted a letter of request to CMS to obtain planning money for developing a health homes model. The money will be used to pay for claims analysis, stakeholder engagement and support, and actuarial work.

The State's preferred model of health homes is envisioned as a broad one, with flexibility to encompass traditional patient centered medical homes as well as health homes centered on non-traditional providers such as community mental health centers (CMHCs) and community developmental disability organizations (CDDOs).

Next Steps

Kansas is now ready to begin working on the state plan amendment (SPA) to implement health homes, understanding work within the project team and with stakeholders will inform the draft, which will be discussed with CMS. The project team already has a sub-group beginning work on quality goals and measures and has had conversations with the State's actuaries and its university partners about claims and financial analysis to support development of health homes in Kansas.

Additional work includes:

- Determining and defining of our target population(s)
- Defining health home services
- Developing provider standards
- Performing detailed claims analysis and developing an algorithm for assignment to a health home
- Developing final goals and quality measures
- Designing the payment structure to support health homes while avoiding duplication of payment
- Educating providers, members and other stakeholders about health homes
- Supporting providers who are interested in becoming health homes

In all of this work, Kansas will consult with stakeholders, including tribal organizations, and work closely with its KanCare MCO partners to ensure that health homes meet the needs of Kansas Medicaid members to improve health outcomes and management of chronic conditions, while reducing unnecessary hospitalizations and emergency room use.